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tive role in humanizing their educational experience. Positive modeling for clinical relationships between physicians and patients has helped first-year students examine their own values and ideals. They now enter their clerkships more aware of the ethical issues and the human values concerns in the practice of medicine, and both medical students and faculty are more conscious of ethics and human values.

Our clear impression is that the effort to humanize medical education at Duke enjoys a broad base of support. The goals speak to a larger audience, and the effort itself communicates a crucial message to both students and faculty.

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ALLEN M. SINGER, Ph.D.

Projections of Physician Supply and Demand: A Summary of HRSA and AMA Studies

Abstract—There is concern that the United States may have a surplus of physicians soon. In a continuation of a movement started around 1980 by the Graduate Medical Education National Advisory Committee (GMENAC) to quantify and project supply and demand for physicians, the American Medical Association (AMA) and the Health Resources and Services Administration (HRSA) have recently produced their latest studies on this subject. The HRSA conclusion, published in its 1988 report to the President and Congress on the status of health personnel in the United States, is that a surplus may come as early as 1990 and will probably worsen by the year 2000. The AMA study, also published in 1988, agrees with the HRSA and the GMENAC that supply will probably grow faster than demand, but it disclaims the notion of a surplus or shortage because that would imply judgments about the adequacy of current utilization rates by all segments of the population. The HRSA report cites a 1986 finding by the Robert Wood Johnson Foundation that access to medical care deteriorated between 1982 and 1986 for minorities and lower-income groups. On the supply side, the HRSA's estimates are somewhat higher than the AMA's, mainly because the former assumes faster growth in foreign medical graduates. Both studies use a demand-based approach to projecting the number of physicians required, but there are considerable differences in the assumptions made about future utilization rates. *Acad. Med.* 64 (1989):235–240.

In recent years the Health Resources and Services Administration (HRSA) and the American Medical Association's Center for Health Policy Research (hereafter in this paper referred to as the AMA) have produced projections of physician supply and utilization to the year 2000 and beyond. Both studies project continued strong growth in physician supply, but they differ in their interpretations of this trend. The HRSA studies tend to support the 1981 conclusion of the Graduate Medical Education National Advisory Committee (GMENAC)[1] that a surplus of physicians will emerge in the United States in the next decade. The sixth and most recent HRSA study in the series shows an explicit excess of approximately 70,000 physicians over requirements in the year 2000,[2] but the report warns of the uncertainties involved in estimating future supply and requirements and urges that the results be interpreted with caution. (This report uses models of supply and demand developed by the HRSA's Bureau of Health Professions.)

The 1988 AMA study[3] concedes that supply will probably grow faster than

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utilization but concludes that such growth does not necessarily imply a surplus. In fact, the AMA quite properly disclaims that its projections can be interpreted as surpluses or shortages because these are normative concepts that involve judgments about the appropriate level of utilization rates. Nevertheless, the AMA—phrasing its results in terms of percentage changes in supply and utilization between 1985 and 2000—concludes that supply will increase by almost 24% over that period compared with a 14.5% increase in utilization.[3] (This study was produced by the AMA's Center for Health Policy Research but the projections have not been endorsed officially by the AMA's House of Delegates.)

Comparison of the Studies

The HRSA and AMA studies can be compared in terms of their supply estimates, demand estimates, specialty requirements, and conclusions.

Supply Estimates

The fact that these studies use somewhat different methodologies makes comparisons of their results difficult, but it is worth noting that the AMA's supply estimates are lower than the HRSA's. For example, the AMA's best estimate of the supply of allopathic physicians in the year 2000 is 633,200,[3] compared with the HRSA's estimate of 667,700.[2] The discrepancy is due mainly to differences in assumptions about the future number of new physicians. As can be seen in Table 1, the AMA assumes a faster decline in the number of U.S. medical graduates (USMGs) between 1986 and 1996 than does the HRSA. Also, the HRSA projections include 1,604 entrants each year from foreign-national foreign medical graduates (FNFMGs) who will enter practice directly without acquiring graduate medical education in the United States. (HRSA then subtracts 720 FNFMGs per year who are expected to return to their home countries.) These new physicians are not included in AMA's projections. Figures 1 and 2 show these projections and

Table 1

Comparison of AMA and HRSA Projections of Annual Entrants to Physician Supply, 1986–96

	AMA		HRSA	
Source of Entrants	1986–87 (n = 18,183)	1995–1996* (n = 16,225)	1986–1987 (n = 19,137)	1995–1996 (n = 18,904)
U.S. medical graduates	15,802	14,222	15,872	15,639
Foreign medical graduates (FMGs)	2,381	2,003	3,265	3,265
U.S.-citizen FMGs	(1,134)	(756)	(1,134)	(1,134)
Foreign-national FMGs	(1,247)	(1,247)	(2,131)	(2,131)
Entering through graduate medical education	(1,247)	(1,247)	(1,247)	(1,247)
Entering practice directly	—	—	(1,604)	(1,604)
J-Visa returns†	—	—	(−720)	(−720)

*Neither the AMA nor the HRSA project any changes in the annual number of new entrants to physician supply after 1996. Source: AMA, see Ref. 3; HRSA, see Ref. 2.

†J-Visas are issued to temporary visitors, who are allowed up to seven years to complete their residency training and then must return to their home countries.

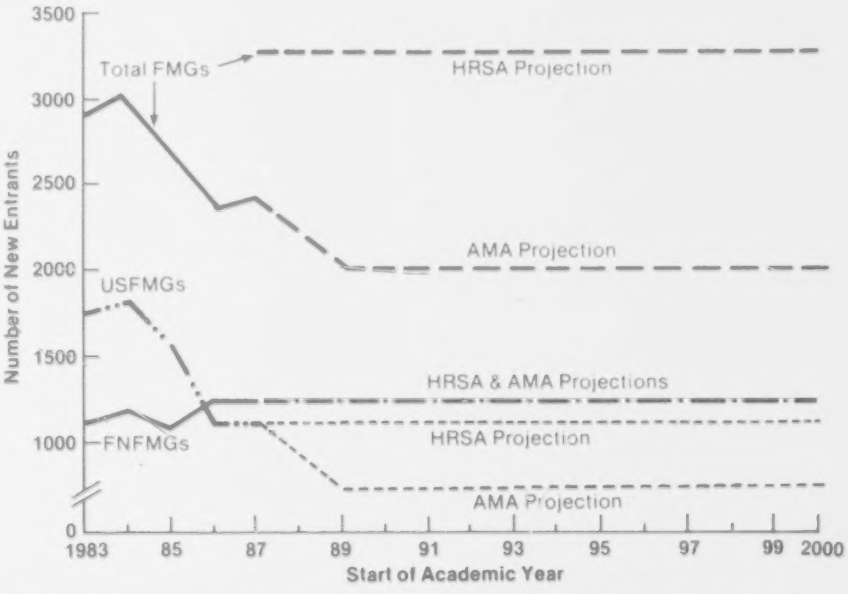

Figure 1. **New entrants to physician supply from foreign medical graduates (FMGs). For 1983–1987, data represent FMGs entering first-year residency programs in September of year shown. Both the HRSA and the AMA use these data to project new entrants to the year 2000. The HRSA's projection of total FMGs is higher than the AMA's because it includes 884 net new entrants each year from FMGs who enter practice directly without going through a U.S residency program. The AMA makes no allowance for this group. (USFMG = U.S. citizen FMG; FNFMG = foreign-national FMG.) Projections (1988–2000) are from the AMA (see Ref. 3) and the HRSA (see Ref. 2); data for 1983–1987 are from the AMA, *Directory of Residency Training Programs* (issued annually).**

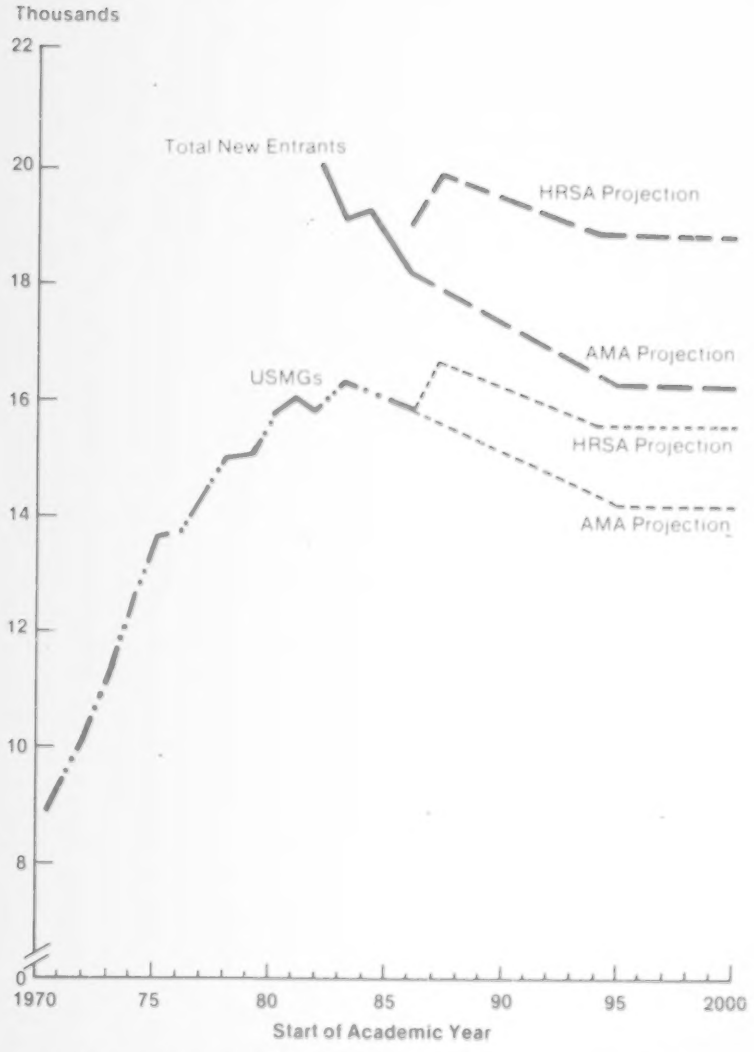

Figure 2. **U.S. medical school graduates (USMGs) and total new entrants each year to physician supply. Total new entrants are defined as USMGs and foreign medical school graduates (FMGs). The HRSA's projections of total new entrants are higher than the AMA's because the AMA foresees a faster decline in USMGs through 1996, and the HRSA includes FMGs thought to enter practice directly without going through a U.S. residency program, while the AMA does not. Data on USMGs for 1970–1986 are from the Association of American Medical Colleges. Data on FMGs for 1980–1986 are from the AMA (see ref. 3); projections (1988–2000) are from the AMA (see ref. 3) and the HRSA (see ref. 2).**

the time series data on which they are based.

The HRSA assumes that first-year enrollments in U.S. medical schools will decline by about 5% between 1987 and 1992. But the number of USMGs will decline by slightly less than that because the HRSA assumes an inflow of about 500 students each year who transfer with advanced standing.[6]

The AMA does not make an explicit projection of first-year enrollments but does assume that USMGs will decline by 10% between 1986 and 1996.

There are other differences in the data used by the AMA and the HRSA that lead to minor differences in supply estimates by the year 2000. For example, the number of active physicians in 1986 in the AMA's Physician Masterfile is used by both studies as the base of their supply projections—to which they add new entrants each year and subtract attrition. However, the AMA estimates the number of allopathic physicians in 1986 at 519,411, while the HRSA's estimate is 521,780. The latter includes 90% of the physicians classified by the AMA as "unknown activity status" or "unknown address." Both studies count each resident as an active physician and include physicians engaged in non-patient-care activities in their supply estimates.

The reports use different data for first-year medical school enrollments from 1982–1987, with the HRSA's numbers[2] being consistently higher than the AMA's[3] by 350–500 per year.

For attrition rates, both studies used data from the AMA's Physician Masterfile to derive age-specific and gender-specific rates for USMGs and foreign medical graduates (FMGs). In addition, the AMA develops attrition rates for each specialty and claims that retirement rates in general internal medicine, the medical specialties, and psychiatry are lower than those in hospital-based specialties (radiology, anesthesiology, and pathology).[3] The AMA also states that women have higher retirement rates than men, and FMGs have lower retirement rates than USMGs.

The HRSA report states that its estimated retirement rates show no major difference between men and women or between USMGs and FMGs.[2]

There are not sufficient data in the reports to reconcile these differences.

Demand Estimates

As might be expected, modeling the demand side involves more complicated calculations than modeling the supply side in these studies. Both the HRSA and the AMA start with physician utilization rates by various population segments in recent years. Then U.S. Census Bureau population

projections are applied to the base-period utilization rates to derive the basic utilization projections. The HRSA then adjusts the basic projections to account for changes in prices, insurance coverage, and other non-price factors that might affect utilization rates—and labels the results "requirements."

The AMA does not make such extensive adjustments to the basic utilization projections, and labels its results "utilization." This subtle difference in terminology perhaps reveals something about the way each organization interprets its results. Although both the HRSA and the AMA are careful to point out that these projections neither define appropriate standards of care nor imply that current utilization rates are appropriate, the HRSA report leaves little doubt about its conclusion that a surplus of physicians will exist by 2000, while the AMA report does not arrive at that conclusion.

The HRSA's projection of requirements for physicians to the year 2000 shows somewhat faster growth (at 1.3% per year) than does the AMA's (at about 0.9% per year). This difference appears to be due mainly to the HRSA's adjustments to the basic utilization projections based solely on population growth, although the report is not at all clear on the magnitude of these adjustments and presents no data concerning them. A separate HRSA document[4] describes the requirements model in more detail and implies that such adjustments are included in the HRSA's requirements projections, but it does not present the data.

The AMA's utilization model assumes "that there will be no major changes in prices, incomes, epidemiology, or other factors that would significantly affect utilization patterns."[3]

Table 2 summarizes as much as can be learned about the approaches taken by the two studies to estimate demand.

Table 2

Summary of HRSA and AMA Models for Projecting Physician Demand

	AMA	HRSA
Units of measurement of physician utilization†	Office and telephone visits, but excluding telephone contacts.	Patient visits and hospital admissions.
Data sources	National Center for Health Statistics: NMCUES (1980) and NHIS (1985).* Utilization data were obtained for 1980 and adjusted to 1985, by specialty, for each sex, race, and age group.	National Center for Health Statistics: NHIS* and the Hospital Discharge Survey. Utilization rates in 1975 were obtained for 40 population segments (defined by age, sex, and income) and 20 forms of health care.
Average increase in demand	0.9% per year increase in total contacts between 1985 and 2000.	1.3% per year increase in requirements between 1986 and 2000.
Assumptions	1. Utilization patterns by age, race, sex, and income will remain constant. 2. Most of the projected increase in physician contacts is expected to be due to a 10% increase in the U.S. population between 1985 and 2000.	Utilization rates will change due to population growth and changes in prices, health insurance, and other non-price factors. Recent trends in these factors will continue. Coinsurance rates (percentage of total cost paid by consumer) will continue to decline.
Treatment of demand for medical specialties	Projections of utilization of 13 specialty groups are explicitly stated.	Projections of requirements by specialty are implied but not explicitly provided. The requirements model developed by the Bureau of Health Professions considers eight categories of physicians and 20 other types of health personnel.

*NMCUES = National Medical Care Utilization and Expenditure Survey. NHIS = National Health Interview Survey.

†Utilization rates are defined as per capita utilization by each population group.

Specialty Requirements

A major difference between the two studies is in the amount of detail provided about physician requirements by specialty. In the HRSA report, the projections of physician requirements are not broken down by specialty, although the Bureau of Health Professions' model used in the HRSA report provides for estimating requirements in eight specialties.[4] This absence of detail is understandable because the HRSA report covers 20 types of health personnel in addition to physicians.

Since AMA's report concerns physicians only, it is able to provide both supply and utilization projections for 13 specialty groups.

Conclusions

The HRSA summarizes its projections for physician supply and requirements in Table 3, which shows an excess of supply over requirements now and for the next 30 years. But the HRSA report also cites a Robert

Wood Johnson survey[5] that concluded that between 1982 and 1986 access to medical care deteriorated among the poor, minorities, and uninsured, especially those in fair or poor health. It is not clear to what extent, if any, the HRSA's requirements projections include an adjustment to correct for this decline in access.

The AMA's projections are shown in Table 4. In this model, pediatrics and the medical subspecialties will experience the fastest growth in supply relative to utilization, while for general surgery the supply will change hardly at all. Utilization of general/family practitioners and psychiatrists is also projected to increase faster than supply. But because there is evidence that current utilization rates are not optimum, the AMA declines to conclude that there will be any surpluses or shortages.

These AMA projections are in the same general direction as the HRSA's, and the AMA also believes that many adjustments could occur to bring the growth rates in supply and utilization closer together. Prices of services and the incomes of physicians in the fastest-growing specialties may decline, thus slowing the growth of those specialists. Changes in medical technology could radically change utilization patterns, and more importantly—as acquired immune deficiency syndrome (AIDS) has shown—the incidence and prevalence of disease are not stable over time and can cause changes in the demand for physicians' services.

Commentary

The AMA and the HRSA are to be commended for producing thoughtful studies of a complex set of issues. Their reports deserve serious review and consideration. They continue to advance the state of the art in modeling physician supply and demand that was established by the pioneering GMENAC effort in 1981.

It is becoming clearer that the supply side is easier to model than the demand side because the former involves less stringent data requirements and fewer factors to consider (although the distribution of physicians by specialty and geography are issues needing further attention). On the requirements side, the HRSA's attempt to adjust for changes in insurance coverage is on the right track—programs such as Medicare and Medicaid are likely to have an even greater impact on the cost and access issues in the future. But the HRSA clearly should provide better documentation of its requirements model and the adjustments made to utilization rates.

The differences between the two studies involving the current supply of physicians, data on FMGs, and attrition rates are matters of interpreting actual data from the same source and ought to be resolved by discussions between the organizations.

As for interpreting the results, there are legitimate grounds for differences. The essential issue here is whether or not current utilization rates are optimum, and neither study claims that they are. If the acknowledged problems of the maldistribution of physicians and lack of access to adequate health care for certain groups were solved, would there still be a potential surplus? Perhaps that question could be addressed more explicitly in future studies.

Table 3

HRSA Estimates of the Supplies of and Requirements for Allopathic and Osteopathic Physicians in 1986 and Projections to 1990, 2000 and 2020*

	1986	1990	2000	2020	Percent Increase 1986–2000
Supply	544,830	597,040	708,600	820,810	30.1
Requirement	—	570,500	637,000	758,500	19.1
Excess of supply over requirement	—	26,540	71,600	62,310	—

*Health Resource and Services Administration, Bureau of Health Professions (BHPr): supply forecasts are from the BHPr Supply Model basic series of estimates; requirement estimates are from the BHPr General Requirements Model.

Table 4

AMA Estimates of Changes in Projected Utilization and Supply of Allopathic Physicians 1985–2000*

	Percent Change in Utilization†	Percent Change in Supply‡	Difference in Percent Changes
All physicians	14.5	23.8	−9.4
Specialty			
General or family practice	13.0	9.9	3.1
All internal medicine	24.0	36.6	−12.6
General internal medicine	24.6	27.0	−2.4
Medical subspecialists	23.4	51.8	−28.4
All surgery	17.0	13.1	3.9
General surgery	16.5	0.5	16.0
Surgical subspecialists	17.1	19.9	−2.8
Pediatrics	7.0	38.8	−31.8
Obstetrics-gynecology	2.8	24.3	−21.5
Radiology	—	18.2	—
Psychiatry	19.4	14.0	5.4
Anesthesiology	—	41.7	—
Pathology	—	9.6	—
Emergency medicine	6.2	69.4	−63.2
Other specialties	14.8	18.1	−3.3

*Source: Marder, W., et al., *Physician Supply and Utilization by Specialty* (Chicago, Illinois: American Medical Association, 1988), p. 121.

†Total physician contacts excluding telephone contacts.

‡Total projected active physicians.

The author thanks Mr. Cultice and William Marder of the AMA for their reviews of and comments on this article.

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ESSAY

DEBORAH BOREK, M.D.

Unchanging Dilemmas in American Medical Education

Abstract—The author reviews "the lietmotiv of unresolved dilemmas" in American medical education: the problems of determining the premedical and medical school curricula and of selecting medical students. She offers suggestions for each area, but cautions that there are no simple answers. *Acad. Med.* 64(1989):240-244.

Those who take an interest in the evolution of American medical education will find a leitmotiv of unresolved dilemmas. In 1847, the American Medical Association (AMA) convention posed three questions regarding undergraduate medical education:

1. What is the best preliminary education for those intending to study medicine?
2. How can [the medical school curriculum] be improved?
3. What system of examination will best insure competence?[1]

These questions are still debated.

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The Premedical Curriculum

There is no consensus as to what changes should be made in the premedical curriculum, although there is unanimity in deploring the status quo. Proposed changes fall into two broad categories: those of the humanist-elitists, who call for a stronger liberal arts background, and those of the scientist-pragmatists, who would push molecular biology and computers. Lewis Thomas, predictably, is in the first camp. He contends that "the atmosphere of the liberal arts college is being poisoned by premedical students" and suggests that "any applicant who is self-labeled as a 'pre-med,' distinguishable by his course selection from his classmates, should have his dossier placed in the third stack of three."[2] He would make one discipline mandatory for all college students, to place them on a common footing and develop their intellectual abilities: classical Greek, which Thomas would restore "as the centerpiece of undergraduate education."

He writes that not only would the college students benefit from this policy: "Perhaps benefiting the most of all are the basic-science faculties of the medical schools, who would once again be facing classrooms of students who are ready to be startled and excited by a totally new and unfamiliar body of knowledge, eager to learn, unpreoccupied by the notions of relevance that are paralyzing the minds of today's first-year medical students already so surfeited by science that they want to start practicing psychiatry in the first trimester of the first year."

I'm not so sure about Lewis Thomas. I think he just wants to shock or amuse us. And his argu-

groups at the end of the workshop was felt by many to be unnecessary. Thus, this year there will be 12 groups (with 13 in each group) meeting three times for an hour each, with no summary meeting. Thus, 12 faculty members will each be involved as discussion leaders for three hours.

Although student evaluation of the project was not solicited (an oversight to be corrected next time), several students remarked informally that the assignment caused students to discuss ethical issues among themselves and to become aware of these problems. Since they had to locate a "good case" to write about, there was a natural tendency to ask each other what they thought about particular cases, and it appears that "ethics" became the center of a great deal of lunch-time and social conversation. In spite of this type of collaboration, apparently only twice were the same patients referred to in more than one study. A great deal of effort appears to have gone into these studies, in spite of the fact that names were checked only to see whether the case studies had been done at all, and non-participation affected only the workshop examination grade. Thus, although it is hard to determine whether the students' skills in the area of medical ethics have improved because of this project, it seems safe to say that their interest in medical ethics has.

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SHORT PAPERS

RICHARD L. HOLLOWAY, Ph.D., KATHRYN L. HALE, M.L.S., and ROBERT E. RAKEL, M.D.

Academic Promotion and Tenure in U.S. Family Medicine Units

Abstract—The authors interviewed by telephone the heads (or their representatives) of 101 of the 120 family practice units in U.S. medical schools in 1987. Each respondent was asked for his or her personal perceptions of the relative importances of research, teaching, patient care, and administrative activities in the academic promotion process. Respondents were also asked for their views of their units' and institutions' perceptions of the importances of the same four activities in the promotion process, as well as other related questions about promotion and tenure. The findings indicate that there is still a significant incongruence between the value structure of most family practice units and that of their institutions but that many family practice units are beginning to achieve parity of promotion and tenure with other departments in their institutions. *Acad. Med.* 64(1989):270–272.

Promotion to associate professor with tenure has numerous implications for the individual faculty member; the departmental implications are equally important. These implications are strong for faculty and departments of family medicine, a specialty that formally began in 1969 and is striving to survive in academic medicine. Existing studies of promotion and tenure in family medicine have shown that research productivity (that is, publications) is the key factor in promotion and tenure decisions.[1,2] Family medicine has had difficulties establishing a firm research base—many of its teachers question the need for research in a practice-based discipline; others cite teaching or supervising schedules or lack of training as barriers. What is clear is that family medicine faculty must share the values of productivity of their institutions to achieve an established base.[3]

Family medicine has taken some major steps toward academic survival, having achieved full departmental status in 108 U.S. medical schools.

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Federal funding programs have been established for undergraduate medical education, residency education, faculty development, and the establishment of departments. The National Institutes of Health has established training programs for new researchers in family medicine in the hope that newly trained fellows will be better prepared to compete for promotion and tenure in the future. To determine the current state of the discipline regarding promotion and tenure, we conducted a survey of all heads of family medicine units in U.S. medical schools during the summer of 1987.

Method

Of the 137 U.S. medical schools and branches listed by the American Academy of Family Physicians, 120 had a family medicine unit in 1987 (108 full departments, 7 divisions, 5 sections). The other 17 schools reported no involvement in family medicine. We telephoned the chair, head, or designated contact person for each of the 120 schools involved in family medicine and were able to interview 101 (84%). Each respondent was asked for his or her personal perceptions of the relative importances of research, teaching, patient care, and administrative activities in the academic promotion process, as well as their views of their units' and institutions' perceptions of the importances of the same four activities in the promotion process. They also were asked to characterize the orientations of their parent institutions (on a continuum from research orientation to teaching orientation) and to state their opinions of whether their units, their colleges or schools, or their institutions had the strongest influence over the promotion and tenure process.

Results

The responses concerning the orientations of the parent institutions were relatively evenly distributed. The same number (18.8%) were considered to be research-oriented as were considered to be teaching-oriented, an additional 18.8% leaned toward a research orientation, 12.9% leaned toward a teaching orientation, and 30.7% were considered to be evenly balanced in their orientations to these areas. A large percentage of the unit heads (30.7%) claimed that the unit itself had the strongest influence over the promotion and tenure process; a larger percentage (53.5%) claimed that the college or school had the strongest influence, while 13.9% thought that the institution had the strongest influence. Two of the 101 responding unit heads did not answer this question.

The heart of the interview was a series of questions about the unit heads' perceptions of the relative importances of research, teaching, administration, and patient care to the promotion and tenure process. They were also asked for their perceptions of the units' and institutions' judgments of the importances of these factors to the promotion and tenure process. All the unit heads judged that the quality of research and publications was the most important criterion in promotion and tenure; they maintained that their units and institutions held the same view. Sheer numbers of publications was perceived to be a more important factor to institutions than to either units or unit heads. The significance of a faculty member's chosen research area was judged by all to be less important than quantity or quality of research or teaching.

The unit heads judged teaching, both quality and quantity, to be more important to promotion and tenure decisions than they felt the institutions did. Administrative contributions were uniformly judged to be the least important of all the criteria to

Table 1

Correlations and Coefficients of Determination of Ratings of the Relative Importances of Research, Teaching, Administrative, and Patient-Care Activities in Decisions Concerning Promotion and Tenure of Family Practice Faculty Members*

Activity and Institutional Categories	Institutional Categories: Head	Unit (Department, Division, or Section)	Institution
Research† ‖			
Head	1.00	.69§	.09
Unit	.83‡	1.00	.08
Institution	.30	.28	1.00
Teaching†			
Head	1.00	.64§	.12
Unit	.80‡	1.00	.25
Institution	.35	.50‡	1.00
Administration†			
Head	1.00	.41	.35
Unit	.64‡	1.00	.34
Institution	.59‡	.58§	1.00
Patient care† ‖			
Head	1.00	.79‡	.48
Unit	.89‡	1.00	.46
Institution	.69‡	.68‡	1.00

*Ratings were made by the authors after they interviewed 101 unit heads (or designated representatives) and asked them their personal perceptions — and their views of their units' and institutions' perceptions — of the importances of the four activities in decisions concerning promotion and tenure. Responses to these questions were obtained from 87 unit heads regarding research, 91 regarding teaching, 88 regarding administrative activities, and 89 regarding patient care.

†For each of the four activities, the numbers below the "1.00" in each column are the correlations and those above are the coefficients of determination.

‡$p < .001$.

§r^2 (coefficient of determination) $\geq .50$.

‖This is a composite of ratings for both quality and quantity.

promotion and tenure decisions. Amount of patient care was judged fairly important to unit heads but not important to the institutions, while quality of patient care was judged to be of much greater importance by all three.

Overall, these results suggested that there were real differences between the units and unit heads on the one hand and their parent institutions on the other in perceptions of the importances of some of the criteria. To test this hypothesis empirically, composite scores were correlated between and among the levels of importance of promotion criteria viewed by the unit heads and the levels perceived by the unit heads to be the views of their units and institutions (Table 1). The coefficient of determination was also calculated for each correlation (by squaring the correlation). Overall, there was substantial correlation between the perceptions of the unit heads and the units, and significantly less correlation between the perceptions of either of these two groups and those of the institutions. This pattern was more pronounced in the agreement among the three groups on the lesser importance of administration.

The results of the questionnaire indicate both important progress for family medicine and some disturbing trends. That 85.1% of the responding units had achieved departmental status is an encouraging sign, for it indicates a level of stability and entrenchment undreamed of in 1969. Furthermore, 85% reported that at least one member of their faculty had achieved tenure. Almost a third (30.7%) of the units claimed to have the greatest degree of influence over the promotion and tenure process, an important indicator of the maturity of these units.

Based on our data, there is still a significant incongruence between the value structure of most family practice units and that of their institutions. Studies of academic productivity suggest that productivity is greatest in those units whose members identify most closely with the value structure of their parent institutions.[3] The present study suggests that many family medicine units are beginning to achieve parity (as measured by any standard criteria) with other departments in their institutions, adhering to the value structures of their institutions without sacrificing their own. Apparently many family medicine units are finding that the development of a research agenda in family medicine may not necessitate abandoning family medicine's primary commitment to patient care and quality teaching. It may even be the case that one day, family medicine will test its own values using the traditional methods recognized by academic medicine.

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